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Testimony of the
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES
Before the
INSTITUTE OF MEDICINE
COMMITTEE ON THE ASSESSMENT OF THE U.S. DRUG SAFETY SYSTEM

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U.S. House of Representatives

I am the staff director of the Subcommittee on Criminal Justice and Drug Policy, chaired by Rep. Mark E. Souder, which has long dealt with all aspects of drug abuse, involving everything from illegal drug abuse and trafficking to addiction treatment.

Drug safety in general and prescription drug abuse in particular are of tremendous importance to every American and to every user of American pharmaceutical products around the globe. We are pleased FDA has asked the Institute of Medicine to examine this critical public health issue. We appreciate the Committee's hard work on this complex, challenging issue and look forward to working with you.

As you know, our nation's drug problems extend beyond illegal drugs, those so-called Schedule I drugs: we are experiencing an epidemic of prescription drug abuse—an epidemic affecting citizens of all ages and all walks of life, and which continues to worsen.

This has been confirmed by a landmark three-year study by the National Center on Addiction and Substance Abuse, "CASA" (released July 7th, 2005). According to the CASA report: "the number of people who admitted to abusing prescription drugs increased from 7.8 million people in 1992 to 15.1 million in 2003—a 93.8 percent jump—seven times faster than the increase in the US population"[1] over the same period. During those same years, abuse of these drugs among teens increased 212 percent.[2] According to this latest data, abuse of controlled prescription drugs "now eclipses abuse of all illicit drugs combined except marijuana" and that prescription drugs on Schedules II through V are now the fourth most abused substance in America.[3] Moreover, this study acknowledges that it underestimates the actual numbers.[4]

To more effectively address America's prescription drug epidemic, the Drug Policy Subcommittee has been given oversight jurisdiction of the FDA. We view the many critical drug safety issues facing our nation through the lens of drug diversion and abuse.

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[1] National Center on Addiction and Substance Abuse at Columbia University, *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the US*, 23 (2005) available at http://www.casacolumbia.org/Absolutenm/articlefiles/380-final_report_not_embargoed.pdf.
[2] *Id*. at 1.
[3] *Under the Counter*, Statement by Joseph Califano, Chairman and President of the National Center on Addiction and Substance Abuse.
[4] *Id*. at 24.

Keeping in mind the Committee's broad mission, we want to highlight a concern that we believe needs to be addressed while evaluating the drug safety system. Specifically: reworking our current system to detect and prevent prescription drug abuse will help create a better overall drug safety system. We look forward to working with IOM on all the points we bring up today; we, too, are seeking ideas, answers, and solutions.

The shorthand way we frame our question is: "how can we prevent the next OxyContin?" This question has three broad and interrelated components, all of which underscore our concerns. We urge the Committee to keep these in mind during your deliberative process.

1. How can prescription drug abuse be better reported to FDA? That is, what changes to our current drug safety system will allow us to be more proactive in detecting prescription drug diversion and/or abuse?
2. How can we cut our reaction time to indications of abuse?
3. What pre-approval incentives can be offered to encourage marketing of products more resistant to diversion and abuse?

This Committee needs to carefully evaluate whether our adverse event reporting systems and current postmarketing surveillance procedures are sufficient to alert us to prescription drug abuse problems as they occur, and if the systems are not sufficient, how they can be improved. We understand that diversion or abuse may or may not be uses anticipated by the labeling process, and are not necessarily "side effects" within the usual definitions. As this Committee considers ways to reorganize and improve reporting, it should reevaluate how diversion and abuse are considered. We urge the Committee to consider recommending that diversion and abuse be defined, treated, and reported as reportable adverse events.

An improved drug safety system must take advantage of tools and data collection options at the state and national levels. As you know, some possible models are the SAMHSA "DAWN" reporting network and the CDC's Sentinel reporting system. In addition, CASA, the National Alliance for Model State Drug Laws, and the Whit House Office of National Drug Control Policy indicate that almost half the States have or will have in place some form of Prescription Drug Monitoring Program (PDMP), but that these programs are not standardized.[5] Congress is also trying to address the issue of state monitoring programs. H.R. 1132, sponsored by Congressman Ed Whitfield and soon to be marked up in the House Energy and Commerce Committee, would create an HHS grant program to provide funding for states to establish or enhance controlled substance monitoring programs. This is the third year in a row that the House will be addressing this issue, and we hope that the Senate will follow our lead. These are approaches that the Committee should consider.

Another necessary consideration is how best to integrate federal and state law enforcement actors into the reporting of diversion and abuse. An avenue for integration could well involve increasing feedback about prescriptions from pharmacies to providers and prescribers, or some variation on that method. We think that such feedback reporting can be designed to be informative and to protect patient privacy. We are pleased to see that this type of approach has been brought up before this Committee on June 8th (known as the Australian approach). Given that (1) prescription drug abuse often varies by region and that (2) prescription drugs are relatively easy to obtain, we believe that such a strategy would be best supplemented by including law enforcement as recipients of that feedback.

[5] *Under the Counter* at 8; Interagency Working Group on Synthetic Drugs, Interim Report, 11 (2005).

There is a need to investigate barriers to reporting—what are they, where are they, and how can they be lowered. For example, in our meetings with pharmaceutical companies, it has been mentioned more than once that MedWatch is underutilized and that it is unclear how aware doctors are of MedWatch, and whether they know how to find it and use it.

Regarding provider-level detection and reporting of diversion and/or abuse, the July 7th CASA report indicates that (1) there is no assurance that physicians or pharmacists have had comprehensive training to recognize diversion and/or abuse; and (2) they may not always detect it.[6] We urge the Committee to investigate development and implementation of continuing training, and how physicians and pharmacists might be encouraged to look for and report diversion and/or abuse. We understand that providers have concerns about efficiency and the demands of their professions that are already great, but we believe that careful study can yield ideas of how to integrate vigilance against drug abuse into the standard operating procedures of the professions.

We have a few additional thoughts about aspects of the reporting system. First, it is worth considering whether the current system's relationship between enhanced labeling (including black box warnings) and reporting could be improved. Our concern is that the system's current structure can potentially serve as a double-edged sword: because black box warnings increase the universe of side effects known and expected, might that at times mean that FDA subsequently receives less reporting about those risks, because they might then be considered "expected" rather than "unexpected"? It is not entirely clear from FDA how it intends to address this unanticipated consequence.

Second, as to ensuring high quality initial reports, should periodic audits be performed to ensure the quality and detail of reports? Perhaps it is worth considering whether original reports, not just summaries filed by companies, should also be submitted to FDA, in order to avoid filtering that may be inevitable as reports pass through the typical pipeline. Third, we understand that one of the difficulties of evaluating drug reporting is determining causality, but in the same vein, what approaches might improve our evaluation of data to understand emerging patterns? Should companies be required to release their own information after a certain period of time or after reporting data suggests particular trends? The key here is feedback plus dissemination of information.

Next, is the accelerated approval process of Subpart H introducing dangers to the public? We now know that there are problems with enforcement of Subpart H requirements, especially with following through on commitments to conduct post-approval clinical trials. As you know, Representative Markey recently released a report highly critical of how both FDA and drug companies have handled the post-Subpart H-approval requirements; he has also stated his intent to introduce legislation to address these concerns.

Surveillance alone, no matter how rigorous, is not sufficient to ensure drug safety and combat diversion and abuse. When safety or abuse problems appear, making a label change may not be adequate. This Committee should consider the merits of proposals involving periodic re-evaluation of drugs (akin to European approaches), which would include review and assessment of both the safety records and the diversion/abuse records. Advocates of this approach state that periodic re-evaluation, every several years, would encourage record-keeping, prompt

[6] *Under the Counter* at 6.

attention, and prompt response to safety and diversion and abuse issues by all actors. In that same vein, is it acceptable that companies are permitted to move to annual reporting of adverse events not deemed "serious and unexpected" after only three years? Given that under our current system, it may take several years even for label changes to be made, warning letters to be issued, or the diversion and abuse potential of a drug to be realized, a longer term could add incentive to accountability and action.

It is also necessary to determine the best way to provide additional incentives for drug companies to pursue abuse-resistant formulation of prescription drugs. When we have posed this question to pharmaceutical companies, each one has emphatically responded by saying "exclusivity."

We suggest additional market exclusivity as an incentive and reward for engineering into a product measures to prevent diversion or abuse, or to encourage searching for alternative with less abuse potential. For example, added exclusivity could be granted to those innovators who could demonstrate that their products provide a substantial benefit against diversion or abuse. This type of provision could be tailored to categories of drugs that are more likely to be abused. Likewise, the generic form of a drug granted such additional exclusivity would have to demonstrate not only bioequivalence but also the presence and effectiveness of the protective measure.

One of the most important points we can make before you today is that all of us who are working on this issue must carefully evaluate the current system to determine its successes and its failures; it is clear to everyone concerned that our drug safety system can and must function better than it does. For that very reason, careful thought, not hasty legislation, is crucial. Let's get this right the first time and create a system that will help medicine, law enforcement, and government work together to improve drug safety, and to quickly and effectively discover and curb prescription drug abuse.

In conclusion, we'd like to work with you as you examine these issues. To that end, we are pleased to say that when your report and recommendations are being finalized, we are very likely to hold a hearing to help your final findings receive as wide an audience as possible. Because Congress will be facing a reauthorization of the Prescription Drug User Fee Act (PDUFA), likely in 2007, it would be very helpful—and I'm sure all the actors concerned agree—if the Committee frames its recommendations in a way that will lend them to be addressed through the PDUFA reauthorization.

To recap our concerns and the questions that our members would likely pose in a hearing:

- How can prescription drug abuse be better reported to FDA? That is, what changes to our current drug safety system will allow us to be more proactive in detecting prescription drug diversion and/or abuse?
- How can we improve reporting quality? How can we increase feedback and dissemination of information? How can we integrate state and federal law enforcement into these efforts?
- How can we encourage prompt response, accountability, and action from parties such as manufacturers and FDA when safety or abuse problems emerge? How can we improve long-term monitoring of drugs?
- How can we cut our reaction time to indications of abuse?

- What pre-approval incentives can be offered to encourage marketing of products more resistant to diversion and abuse?

Thank you for bringing your expertise and attention to these very important public health issues.